TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, April 22, 1903.

The President, Lucius W. Hotchkiss, M.D., in the Chair.

THE CHEMISTRY OF THE BLOOD IN CANCER; A NEW HYPOTHESIS FOR THE ETIOLOGY.

Dr. John Rogers read a paper with this title, for which see page 280.

Dr. Charles G. L. Wolf dwelt upon the exceeding difficulty of the line of investigation undertaken by Dr. Rogers, and the perseverance that had been shown in the work thus far. The entire question of the carbohydrates in the blood, even under physiological conditions, was still unsettled,—the necessary analyses being exceedingly difficult and the results ofttimes unsatisfactory. When one bore in mind that Dr. Rogers was working upon operative cases, where even the collection of the blood was no easy matter, the obstacles surrounding the problem were more readily appreciated. The line of research was exceedingly suggestive, and the speaker said he felt certain that results would be obtained therefrom.

Dr. Willy Meyer said he recalled one case of carcinoma of the breast in a woman with far advanced diabetes. The family insisted on surgical interference on account of the great pain the patient had to suffer. Radical operation was done, and the patient died of diabetic coma forty-eight hours after the operation.

Dr. Rogers said that in reviewing the literature of the subject he found that apparently the only disease which was incom-

patible with cancer was diabetes. Among thousands of cases of diabetes, including those in the St. George Hospital Reports, he had only come across a single exception to this rule, and that was a case of cancer of the pancreas found at autopsy. The speaker said that while cancer no doubt developed in diabetic patients, that occurrence was extremely rare.

CARCINOMA OF THE BLADDER; COMPLETE EXTIRPATION OF THE BLADDER; RECTAL IMPLANTATION OF ONE URETER.

Dr. George Woolsey presented specimens obtained from a man thirty-seven years old, an alcoholic. He denied syphilis, but had had gonorrhœa several times, the last attack having occurred about four months previous to his admission to the hospital. A month after the onset of his attack he began to suffer from frequent micturition and hæmaturia. Six weeks before he came to the hospital he began to feel a dull, aching pain in the region of the bladder; this pain was fairly constant, and worse during micturition. The urine was passed every two or three hours. The patient was losing flesh and strength.

When he was admitted to the hospital, an examination per rectum revealed that the right lobe of the prostate was enlarged, irregular, and slightly tender. On June 2, 1902, Dr. Eliot opened the bladder above the pubes and found a sessile tumor occupying the region of the trigone and adjacent posterior wall. The tumor felt rather hard, bled freely upon manipulation, and was curetted.

This operation was not followed by any permanent improvement, and when Dr. Woolsey first saw the patient, in July, his condition was pitiable. The urine was foul and filled with blood and pus. The patient was still losing flesh and strength, and had a septic temperature and appearance. Without encouraging him as to the outcome of the operation, he was told that the only hope of cure or relief lay in complete removal of the bladder. This operation was undertaken by Dr. Woolsey on July 18, 1902, the idea being, if possible, to implant the ureters into that part of the bladder-wall which was healthy and could be left, or to save those sections of the bladder-wall where the ureters entered and implant these sections, together with the ureters, into the rectum.

Upon reopening the previous suprapubic wound, which still persisted as a fistula, the bladder was found to be completely filled with a tumor, which bled so profusely that nothing could be done from the inside. The cavity was thereupon packed, and the entire bladder shelled out from its peritoneal covering, without injuring the latter. Upon reaching the ureters, the right ureter was found to be much thickened and dilated and secreting pus. A catheter was sutured into it, and it was allowed to drain into a vessel outside. The left ureter was apparently normal, and it was implanted directly into the rectum, projecting free for one-half of an inch. The original idea of implanting it into a healthy area of bladder-wall or of excising with it a section of the bladder-wall had to be abandoned, because, in shelling out the bladder, its entire blood supply was cut off, and the bladder-wall at the openings of the ureter was involved in the neoplasm.

The patient bore the operation very well. The secretion from the right ureter gradually cleared up. The rectum for a time was intolerant to the urine which was secreted into it by the left ureter, but after two to three weeks had elapsed toleration became fairly well established and the patient was able to hold his urine for several hours. He felt much more comfortable and gained some flesh and strength, although he never left his bed. Towards the end of September he again began losing ground, and on November 2, about three and one-half months after the operation, he died. The autopsy showed a double pyelonephritis. In the left kidney this condition was probably due to an ascending infection from the rectum, although it may have commenced before the operation. Such an infection, Dr. Woolsey said, might probably have been avoided had it been possible to implant with the ureter a small section of the bladder-wall.

The diagnosis of the bladder growth was carcinoma. The patient also had pulmonary tuberculosis. There was some infiltration of the pelvic glands.

SEPTIC PERITONITIS DUE TO THE PRESENCE OF A RUBBER CATHETER IN THE PERITONEAL CAVITY.

Dr. Woolsey presented specimens obtained from a girl, eighteen years old, who was married on January 1, 1902, and was delivered of a full-term child on March 27 of the same year.

Ten days after her confinement she had a chill and some fever, together with considerable vaginal discharge, and received uterine irrigation at the Lying-in Hospital, where she remained in bed three weeks after labor.

Subsequently, several days before admission, the patient developed symptoms of septic peritonitis, and was operated on by Dr. Woolsey, the abdomen being opened in the median line. He came down upon a mass of thickened omentum studded with several small abscesses, and after separating it from the anterior abdominal wall he found that it consisted of a coil of omentum, about three inches wide, which surrounded a section of rubber catheter. The latter was covered with white incrustations, and its lower extremity was adherent to the fundus of the bladder. The peritoneal cavity contained free seropus. The sign of an opening could be discovered on the bladder-wall.

The anterior surface of the uterus was exposed, and a careful inspection failed to show any lesion on its surface or in the uterovesical pouch. On account of the adhesions, its posterior surface was not within reach. The peritoneal cavity showed a diffuse peritonitis, was thoroughly cleansed by irrigation, and drainage made through both flanks. After an infusion of 1000 cubic centimetres, the patient made an uneventful recovery. She could not state whether the catheter had found its way into the peritoneal cavity through the bladder, the vaginal fornix, or the uterus; although an attempt had evidently been made to introduce it into the latter cavity to bring on an abortion.

An examination of the exudate from the peritoneal cavity showed non-pathogenic bacteria, the result of a dirt infection.

BULLET AND WAD OF CLOTHING REMOVED FROM THE PERITONEAL CAVITY.

Dr. Forbes Hawkes presented specimens obtained from a boy who had recently been shot by his father. The ball (.32-caliber) entered the body anteriorly, four inches below and an inch and a half to the right of the nipple line. When the patient was brought to the hospital, shortly after receiving his injury, there were few symptoms of shock. His pulse, however, became weak and rapid, and there was distinct rigidity of the right

rectus abdominis muscle. Diagnosis of hæmorrhage was made into the peritoneal cavity.

Acting upon the supposition that the bullet had passed through the liver, an incision was made through the right rectus muscle. This revealed a perforation of the liver. The bullet had fractured the eighth rib, penetrated the pleural cavity, perforated the diaphragm, entered the liver on its upper or outer surface, and emerged at a point corresponding to the Spigelian lobe below. A further search revealed the bullet and a wad of clothing resting just below the posterior peritoneum, about an inch below the liver and just to the inner side of the right kidney. At the time the boy received his injury he wore an overcoat, a sweater, a shirt, and an undershirt, and the wad found with the bullet was made up of a section of all these articles of clothing. The bullet had carried this wad of clothing with it in its passage through rib, pleura, diaphragm, and liver. The hæmorrhage from both liver wounds was stopped by packing.

The patient made an uneventful recovery from the operation. The leucocyte count at the time of operation was 45,000.

Dr. Hotchkiss mentioned a case of shot-wound of the liver operated upon by him where the pistol-ball had passed from in front directly through the right lobe and lodged somewhere in the back of the abdominal cavity, narrowly missing the inferior vena cava and not wounding the intestines. The man recovered, but about eight months later he suddenly died. At the autopsy, which was made by the coroner's physician, the intestines were found filled with blood. The source of the hæmorrhage could not be learned, but it is possible that a small aneurism had developed as the result of his injury, and in the course of time had ruptured. The bullet was never found. Of course this may have been a case of typhoid intestinal hæmorrhage, but the body was removed, and the bare facts as reported were all that could be learned.